MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

29075

PLACE OF DEATH

County Stone

Township Williams

or

Village

or

City (NO. , St.: Ward)

Registration District No. 547

Primary Registration District No. 6112

File No.

Registered No.

[If death occurred in a hospital or institution, give its NAME instead of street and number]

FULL NAME Clarence Wheeler

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (Write the word)
M	White	

DATE OF BIRTH: March (Month) 23 (Day) 1913 (Year)

AGE: 12 yrs. 6 mos. 5 ds. If LESS than 1 day, ___ hrs. or ___ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

BIRTHPLACE (City or town, State or foreign country) Stone county Missouri

PARENTS

NAME OF FATHER Elbert B. Wheeler

BIRTHPLACE OF FATHER (City or town, State or foreign country) Stone co. Mo.

MAIDEN NAME OF MOTHER Josephine Coker

BIRTHPLACE OF MOTHER (City or town, State or foreign country) Stone Co. Mo

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elbert B Wheeler

(ADDRESS) Viola Mo

Filed 9/28, 1925 J E Chappell REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH September 28 (Month) (Day), 1925 (Year)

I HEREBY CERTIFY, that I attended deceased from ___, 191___, to ___, 191___, that I last saw h___ alive on ___, 191___, and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows: By accident caused by cave in mill

(Duration) ___ yrs. ___ mos. ___ ds.

Contributory (SECONDARY)

(Duration) ___ yrs. ___ mos. ___ ds.

(Signed) J R Lawrence M. D.

191___ (Address) Viola Mo

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted if not at place of death?

Former or usual residence

PLACE OF BURIAL OR REMOVAL: McCullough Cemetery

DATE OF BURIAL: Sept 29th 1925

UNDERTAKER: C M Borgh

ADDRESS: Viola Mo

8. OCCUPATION (a) Trade, particular kind of work (b) General nature of business, or establishment in which employed (or employer)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. AGE should be stated EXACTLY. PHYSICIANS are requested to supply information under SECONDARY.

PLACE OF DEATH

County _____

Township _____ or Village _____ or City _____ (NO. _____, _____ St.: _____ Ward)

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Registration District No. _____ File No. _____

Primary Registration District No. _____ Registered No. _____

[If death in hospital, give full name of street.]

FULL NAME _____

PERSONAL AND STATISTICAL PARTICULARS

SEX	COLOR OR RACE	SINGLE MARRIED WIDOWED OR DIVORCED (*Write the word*)

DATE OF BIRTH _____ (Month) _____ (Day) _____, (Year)

AGE _____ yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. or _____ min.?

OCCUPATION
(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

BIRTHPLACE (City or town, State or foreign country) _____

PARENTS

NAME OF FATHER _____

BIRTHPLACE OF FATHER (City or town, State or foreign country) _____

MAIDEN NAME OF MOTHER _____

BIRTHPLACE OF MOTHER (City or town, State or foreign country) _____

THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) _____

(ADDRESS) _____

Filed _____, 191____, _____
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

DATE OF DEATH _____ (Month) _____

I HEREBY CERTIFY, that I attended deceased _____, 191____, to _____ that I last saw h____ alive on _____ and that death occurred, on the date stated above. The CAUSE OF DEATH* was as follows:

_____

_____

_____ (Duration) _____ yrs. _____ mos.

Contributory _____
(SECONDARY)

_____ (Duration) _____ yrs. _____ mos.

(Signed) _____

_____, 191____ (Address) _____

*State the Disease Causing Death, or, in deaths from Violence (1) Means of Injury: and (2) whether Accidental, Suicidal, or Homicidal.

LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____

Where was disease contracted if not at place of death? _____

Former or usual residence _____

PLACE OF BURIAL OR REMOVAL	DATE OF
UNDERTAKER	ADDRESS